STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING **01** B. WING _____	R **01/15/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEN HUR HEALTH AND REHABILITATION	**1375 S GRANT AVE** **CRAWFORDSVILLE, IN 47933**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/23/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 01/15/16

Facility Number: 000461
Provider Number: 155401
AIM Number: 100275290

At this PSR survey, Ben Hur Health and Rehabilitation was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.

This facility, which consisted of one story building additions with a partial basement to a two story facility, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in resident Room 612 and 613 in Wing 9. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 110 and had a census of 88 at the time of this survey.

All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached equipment storage and maintenance building.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING **01** B. WING _____	R **01/15/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEN HUR HEALTH AND REHABILITATION	**1375 S GRANT AVE** **CRAWFORDSVILLE, IN 47933**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 Quality Review completed on 01/19/16 - DA	{K 000}		